MDR Tracking Number: M5-05-1787-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-25-05.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

The office visits, chiropractic manipulation, therapeutic exercises, manual therapy, distinct procedural service, group therapeutic procedures, mechanical traction therapy and non-prescription drugs for 3-30-04 through 5-21-04 **were not found** to be medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-22-05 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT code 99214 on 3-30-04: Neither the carrier nor the requestor provided EOB's. The requestor did not submit convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend no reimbursement.**

Regarding CPT code 99080-73 on 3-30-04: Neither the carrier nor the requestor provided EOB's. The requestor did not submit convincing evidence of carrier receipt of provider's request for EOB's in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend no reimbursement.**

Regarding CPT code 99080-73 on 4-14-04, 5-19-04, and 5-21-04: The carrier denied these services as unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. This dispute will be forwarded to Compliance and Practices for this violation of the Rule. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of $45.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees totaling $45.00 from 4-14-04 through 5-21-04 outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Decision and Order is hereby issued this 11th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO decision

NOTICE OF INDEPENDENT REVIEW DECISION

May 3, 2005

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-05-1787-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 52 year-old female injured her back, right shoulder and legs on ___ when she slipped and fell on a wet floor landing on her back. She has been treated with medications and therapy.

Requested Service(s)

Office visits, chiropractic manipulation, therapeutic exercise, manual therapy, distinct procedural service, group therapeutic procedures, mechnical traction therapy, non-prescription drugs for dates of service 03/30/04 through 05/21/04

Decision

It is determined that there is no medical necessity for the office visits, chiropractic manipulation, therapeutic exercise, manual therapy, distinct procedural service, group therapeutic procedures, mechanical traction therapy, non-prescription drugs for dates of service 03/30/04 through 5/21/04 to treat this patient's medical condition.

Rationale/Basis for Decision

The Guidelines for Chiropractic Quality Assurance and Practice Parameters Chapter 8 under "Failure to meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Therefore, there is support for the initial 4-6 weeks of treatment that ended prior to the disputed dates of service. However, on a variety of bases, there is no support whatsoever for the continuing of treatment after 03/29/04.

There is no documentation that manipulation was ever performed and thus no basis under CPT2 for the chiropractic manipulative therapy codes that were utilized. In fact, the provider in 4 separate treatment plans stated that mobilization (not manipulation) was being performed.

Physical medicine treatment requires ongoing assessment of a patient's response to prior treatment and modification of treatment activities to effect additional gains in function. Continuation of an unchanging treatment plan, performance of activities that can be performed as a home exercise program and/or modalities that provide the same effects as those that can be self applied are not indicated. Services that do not require "hands-on care" or supervision of a health care provider are not considered medically necessary services even if the services are performed by a health care provider.

In regard to therapeutic exercises, they may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of the options being home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level the provider has failed to establish why the services were required to be performed one-on-one when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises." After several weeks of monitored exercises, the patient should have certainly been able to perform the exercises on her own. The records failed to substantiate that the disputed services fulfilled statutory requirements for medical necessity since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to or retain employment. The provider's examinations dated 03/30/04, 04/12/04, and 05/17/04 indicate that the opposite was true since the patient actually regressed during the time period in question. Specifically, the patient's low back pain increased from 5/10 on 03/30/04 to 7/10 on 05/17/04; and her cervical and lumbar ranges of motion decreased from the time of the 03/30/04 examination to the examination performed 04/12/04. Therefere, the office visits, chiropractic manipulation, therapeutic exercise, manual therapy, distinct procedural service, group therapeutic procedures, mechnical traction therapy, and non-prescription drugs for dates of service 03/30/04 through 05/21/04 were not medically necessary to treat this patient's condition.

Sincerely,

Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:dm

Attachment

Information Submitted to TMF for TWCC Review

Patient Name:

TWCC ID #: M5-05-1787-01

Information Submitted by Requestor:

- Treatment Notes
- Letter of Medical Necessity
- Consult

Information Submitted by Respondent:

- Treatment Notes
- Claims